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**Decentralization
and
National Health Policy Implementation
in Uganda – a Problematic Process**

Anders Jeppsson

Malmö 2004

Abstract

Background: The Ugandan Government has aimed at creating a needs-based and cost-effective health care system. The means to carry out this aim have been 1) a decentralization of the health sector in order to increase lower-level responsibility, accountability, and participation, and 2) a strong national policy formulation capacity, facilitating needs assessment and cost-effective prioritization.

Aim: The aim of this study is to investigate the process of ascertaining goal achievement with regard to needs-based health care services and national health policy implementation in the decentralized health care system of Uganda.

Population and method: The health sector of Uganda is examined from the national to the district level. Focus is on the process of decentralization, which includes a more efficient mechanism for implementing policy goals throughout the decentralized system, since traditional hierarchical methods of directing institutions become obsolete. In order to study the implementation process, the theoretical framework of new institutionalism has been employed. The several papers in this thesis focus on understanding the prerequisites of policy implementation in a decentralized system. In the final paper, the outcome of a full-scale policy implementation trial is assessed and interpreted against the background of the previous studies. The concepts of diffusion and translation have been adopted from the theoretical framework of new institutionalism in organizational theory, and are used as tools in the analysis.

The methods employed for data collection in different parts of the study have been interviews, questionnaires, focus group discussions, and document analysis.

Results: Financial decentralization was studied under the assumption that districts would prioritize health care financially in implementing the new national health policy. It was, however, observed that this was not the case.

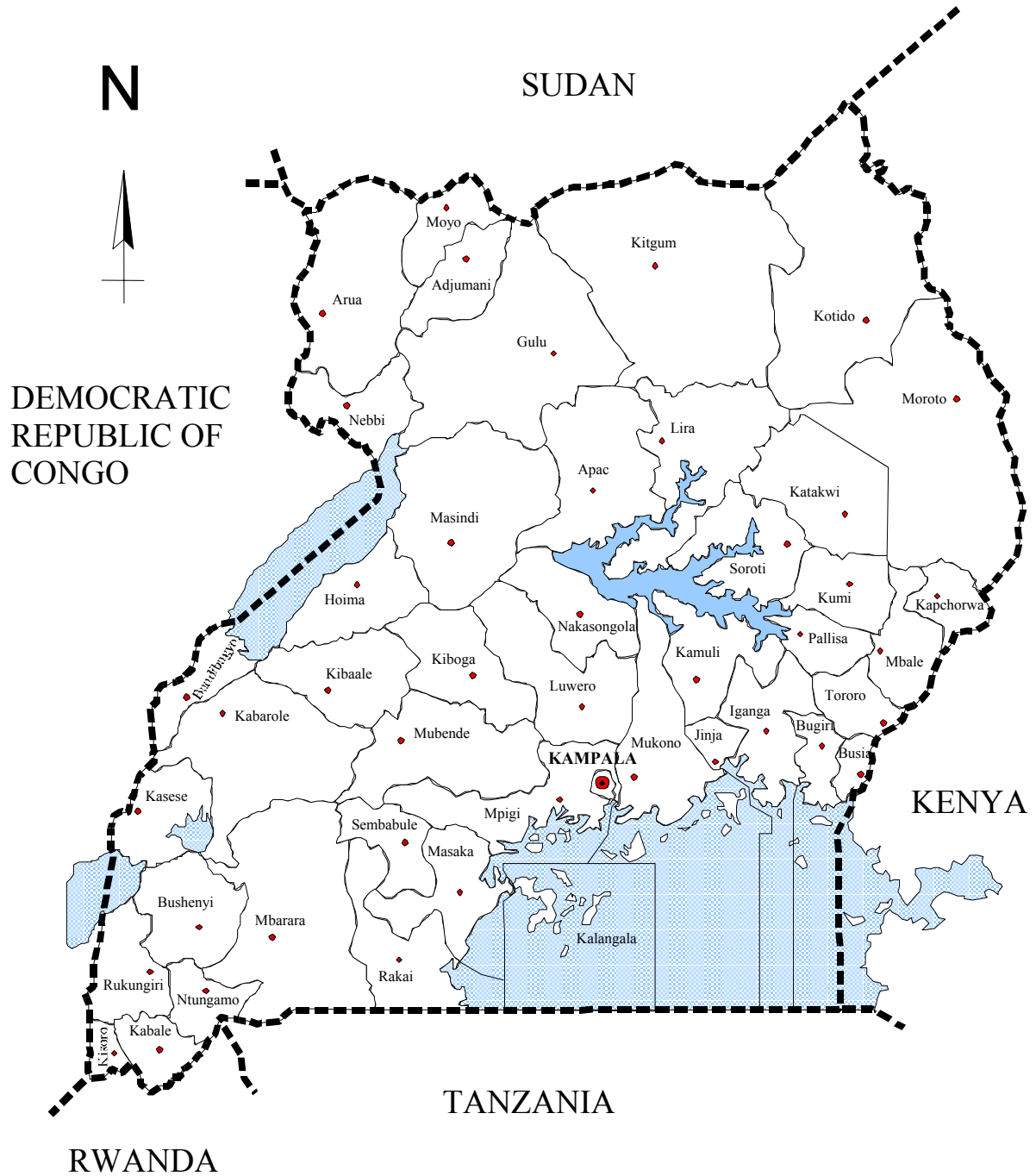
As the Sector-Wide Approach Process (SWAP) was studied, it was observed that, while the policy formulation capacity of the Ministry of Health (MOH) (which is no longer supposed to focus on detailed health systems planning as in the past) became stronger, the central level had difficulties in maintaining efficient interaction with those responsible for implementation. This had resulted in an increasing gap between the centre and the periphery.

The adoption of new policies, paradigms, and strategies, such as SWAP, the restructuring of the MOH, and the formulation of a new health policy, has strengthened ties with the global institutions. Sharing paradigms and values has probably further promoted the independence of the MOH. Also studied was the application of two normative rationalist instruments, Burden of Disease (BOD) and Cost-Effectiveness (CE), intended to implement national health policy priorities at a district level. This application was a failure.

Discussion: The increasing decentralization of the health care system in Uganda during the period studied has not been followed promptly by the implementation of a global national health policy necessary for a decentralized system. It appears as if the government assumed that new health policies could be implemented by means of a fairly uncomplicated process of diffusion. However, an analysis of the near total failure of the BOD/CE initiative shows that implementation of policy in the decentralized system in Uganda is complex and must be understood as a misdirected translation process whose prerequisites were lacking.

The main factors that have inhibited the adoption of a new policy and have created a gap between centre and periphery have been different values, the absence of a common frame of reference, and the lack of government support. As a result, local obligations and local accountability have been the main factors guiding the translation.

UGANDA



The head won't get far without its feet

Eastern Central African proverb

Abbreviations

ACAO	Assistant Chief Administrative Officer
ADDHS	Assistant District Director for Health Services
AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infections
BOD	Burden of Disease
CAO	Chief Administrative Officer
CE	Cost-Effectiveness
CORPS	Community Resource Person
DLY	Discounted Life Years
DMO	District Medical Officer
DDHS	District Director for Health Services
DGHS	Director-General (Health Services)
DHMT	District Health Management Team
DHC	District Health Committee
GOU	Government of Uganda
HFA	Health for All
HPAC	Health Policy Advisory Committee
HPD	Health Planning Department
HPIC	Health Policy Implementation Committee
HSD	Health Sub-District
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committee

JRM	Joint Review Mission
LC	Local Council
LC-III	Sub-County Local Council (III)
LC-V	District Local Council (V)
MOFPED	Ministry of Finance, Planning & Economic Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
NGO	Non-Governmental Organization
NRM	National Resistance Movement
PCO	Projects Coordination Office
PS	Permanent Secretary
PHC	Primary Health Care
RC	Resistance Council
RDC	Resident District Commissioner
SCHC	Sub-County Health Committee
STD	Sexually Transmitted Disease
SWAP	Sector-Wide Approach
UEDMP	Uganda Essential Drugs Management Programme
UEDSP	Uganda Essential Drugs Support Programme
UK	United Kingdom of Great Britain and Northern Ireland
USA	United States of America
WB	World Bank
WHO	World Health Organization

List of publications

The following publications, upon which this thesis is based, will be referred to by their Roman numerals:

- I. Jeppsson A (2001). Financial priorities under decentralization in Uganda. *Health Policy and Planning* 16(2):187-192.
- II. Jeppsson A (2002). SWAP dynamics in a decentralized context: experiences from Uganda. *Social Science and Medicine* 55:2053-2060.
- III. Jeppsson A, Östergren PO, and Hagström B (2003). Restructuring a ministry of health: an issue of structure and process. *Health Policy and Planning* 18(1):68-73.
- IV. Jeppsson A, Birungi H, Östergren PO, and Hagström B. The global/local dilemma of a Ministry of Health: a case study from Uganda. *Health Policy* (In press).
- V. Jeppsson A, Okuonzi S A, Östergren PO, and Hagström B. Application of Burden of Disease/Cost-Effectiveness Analysis as an instrument for district health planning: experiences from Uganda. *Health Policy* (In press).

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The problem

According to contemporary sources, the general health status in Uganda, as well as the quality of health services, is poor. The present situation is the result of a worsening during the 1990s. The government has addressed the issue of poor health and a dysfunctional health care system by undertaking an extensive decentralization of the whole public sector and the adoption of a new national health policy. Considerable funds have been expended in trying to make these reforms work. The present thesis is an examination of the actions taken to improve public health and those factors that have been impediments in this process.

Personal point of departure

Since I became interested in health planning while studying medicine some three decades ago, I have been fascinated by the fact that even the most careful planning can unexpectedly lead to results other than intended goals. In the health sector, failure to achieve one's goals is generally perceived as a personal failure for those involved in planning. In areas other than public health, as, for example, in the social or political sciences, an implementation failure is seen as an issue requiring further research rather than a human weakness. Historians often analyze ambitious plans that have failed, although those responsible for health policy and health planning do not seem to take this approach.

Until a decade ago, the international literature on health policy dealt almost exclusively with substantive content. The policy formulation process was viewed as a rather mechanical action, and implementation was not even seen as an issue. Eventually, the variables of process and context were added to the content of the policy formulation (e.g., Walt 1994). Health policy was increasingly considered a political issue, and elements of social and political science were appropriated. Over time, the debate on policy formulation has primarily dealt with external processes and power, but cross-fertilization among practitioners in health policy (planning and management on one side, and social and political scientists on the other) has yet to result in planning for optimal health. Debate is still characterized by a lack of empirical evidence deriving from the implementation level. Actual implementation is still largely taken for granted, instead of being viewed as an issue that needs to be studied and fed back into the policy formulation process (Walt 1994, Jönsson 2002).

When I came to Uganda in 1996, I became involved in the initial capacity-building process of a health care system that had largely collapsed. My overall task

was to ensure that basic health services were provided throughout all the districts of Uganda; to see to it that available resources were put to the best possible use; and to improve the management process at the MOH, as well as at lower levels. My previous job assignments in Zambia (1990–1993) and Ethiopia (1994–1996) had been as a technical advisor to the respective MOHs. In Uganda, this role was expanded to include planning and management at local level, which put me in a unique position to closely follow the decentralization process from the central down to the district and even lower implementation levels. This thesis will highlight some of the policy implementation problems that were encountered in Uganda, in the hope that it may help improve future implementation management, in that country and elsewhere.

Policy implementation

Policy formulation and implementation are processes that take place in a context. These processes and contexts can change the substantive policy *content* (Walt 1994). The same is true of policy implementation. To determine whether implementation is a rational process, the meaning of rationality must be defined. In the 1960s and early 1970s, a strong rationalistic tendency tried to convert politics into an almost scientific enterprise (Pressman & Wildavsky 1973; Vedung 1997). A whole spectrum of ‘scientific’ methods like zero-based planning, programme-budgeting, cost-effective analysis and strategic planning were developed to replace short-sighted rules of thumb that had been used to manage social problems. The most far-reaching manifestations of this period have been referred to as “radical rationalism” (Wittrock & Lindström 1984), and even “naïve rationalism” (Hayek 1974; Popper 1978), as opposed to “critical rationalism”, which elevates both unexpected side-effects or reverse effects to the heights of rationality (Vedung 1997).

Rationality can be defined as “the quality of being consistent with or based on logic” or “the state of having good sense and sound judgement” (www.hyperdictionary.com). Logic, good sense and sound judgement, however, mean different things to different people, and are subjective values. “Rationality is concerned with the selection of preferred behaviour alternatives in terms of some system of values whereby the consequences of behaviour can be evaluated” (Simon 1997). What is rationality to one person may not be so to another. One connotation of the word “rationalist” is a “false reasoner” (www.webster-dictionary.org). The question that must be posed is: *Whose rationality counts?*

In my endeavours to strengthen health policy implementation in Uganda, I concentrated increasingly on identifying those factors that could facilitate the implementation of health policies of all kinds, and which factors could restrain the same processes.

This thesis is intended to present empirical data from a series of comprehensive reforms in order to demonstrate how these came to play against each other in unexpected ways, and to analyze why this happened.

The case of Uganda: what general conclusions can be drawn?

Since the current Ugandan Government came to power in 1986, one of its priorities has been to create a needs-based and cost-effective health care system (MOH 1999c). In order to do this, two main strategies have been applied:

- 1) a decentralization of the health sector in order to increase responsibility, accountability, and participation on the lower level
- 2) a strengthened national policy formulation capacity, based on needs assessment and cost-effective prioritization

As an eastern Central African nation, Uganda faces many challenges with regard to its living conditions — health being one of them. The government of Uganda (GOU) undertook a vast reform of the public sector in the 1990s. It included one of the most radical and comprehensive decentralization programmes ever attempted on the African continent. This decentralization has led to a strong, well-structured government system on the local level, which in turn provides a dynamic basis for further reforms and the expansion of social services, including health.

Uganda has become a laboratory for social experiments and reforms, many of them advocated by international organizations and bilateral donors, and accepted with general enthusiasm by the Ugandans. As the environment for reform has been favourable, changes have probably occurred faster than they would have in many other countries. Also, by virtue of its well-established system of local government, Uganda differs from other low-income countries in Africa and elsewhere. Still, there are similarities that make generalisations of findings in the Ugandan context relevant to other low-income countries.

Uganda has gone from a period of civil war and genocide to one of stability, openness, and relative peace, and has grown economically over the last decade. It is one of only two countries in sub-Saharan Africa where the incidence of HIV is on the decline. The environment in Uganda offers an opportunity to obtain ‘thicker’ (Geertz 1973) or more concentrated, richer, data. One might say that the soil in Uganda is very fertile, not only for crops, but for social experiments as well.

Aims

General aim

The aims of this study are a) to investigate the process of strengthening needs-based health care services by implementing a decentralized national health policy in Uganda, b) to identify possible impediments to achieving the such a goal, and c) to examine the usefulness and limitations of selected theories (i.e., diffusion and translation of ideas) in the context of policy implementation and health sector reform.

Specific aims

- 1) to investigate how the decentralization of power has influenced a district's health allocations, and the justifications given;
- 2) to investigate how the SWAP process has influenced the power relations in the health sector, particularly between the central and peripheral levels;
- 3) to investigate how the restructuring of the MOH has influenced its relationship with the districts;
- 4) to investigate how the introduction of new health policies, paradigms, and strategies has influenced relationships between (a) the MOH and the global expert community, and (b) the MOH and the implementation level;
- 5) to investigate whether district health budget allocations and actual expenditures for health services followed the BOD/CE district analysis, and the impact other justifications have had on budgeting and expenditures in the districts.

Setting, theory, study design, and methods

Demography and geography of Uganda

Uganda is a landlocked country, situated on the Equator just north of Lake Victoria in eastern central Africa. Its neighbouring countries are Kenya, Tanzania, Rwanda, the Democratic Republic of Congo, and the Sudan. Uganda has a total area of approximately 236,000 sq. km. The current population is estimated at 25 million, of which more than half are below age 15. The average life expectancy at birth is estimated at 42 years. The annual population growth rate is about 3.1%. Approximately 85% of the population lives in rural areas, with the majority working in the agricultural sector at subsistence livelihoods dependent on seasonal rainfall. The industrialized sector remains poorly developed, particularly outside of Kampala, the capital.

With the coming of a new government in 1986, Uganda has embarked on a route of expedited economic development, its goal being to achieve macro-economic growth and relatively broad-based stability in a short time. The Gross Domestic Product has expanded at an annual rate of over 7% from 1990 onwards, while inflation has remained at less than 5% annually. Despite impressive recent statistics, Uganda it is still among the poorest countries in the world, with a per capita gross national income of USD \$249 per annum (UNDP 2003).

Brief history of Uganda

The Uganda Protectorate was established in London in 1894 as a result of competition between the colonial powers—Britain, France, and Germany—for control of African territory and the Nile. When the protectorate gained independence in 1962, the process was a peaceful one, but conflicts were implicit in the foundations of the state. Uganda's first Prime Minister, Milton Obote, ascended to the presidency by means of a coup in 1966. This event was followed by twenty years of unrest, civil war, and genocide. Coups succeeded one another, and the cruelty and bloodshed during the regime of Idi Amin (1971–1979) and the second regime of Milton Obote (1980–1985) reached levels that echoed throughout the world.

It was not until the current president, Yoweri Kaguta Museveni, seized power in 1986, that peace was returned to the country. The period since 1986 has been

characterized by political stability, democratization, and economic growth (Vilby 1998).

An extensive programme of reforms in the public sector, all part of the democratization process, have been carried out during 1990s: decentralization of the government, reorganization and restructuring of the civil service, economic recovery programmes, privatization, demobilization of the army, and constitutional reform (Villadsen 1996).

Political and administrative organization

Political decentralization of the government of Uganda dates back to the war of liberation, fought between 1981 and 1986. During the war, the National Resistance Movement (NRM) introduced a system of elected councils that governed at various local levels in the areas under its control. The people were thereby given the opportunity to elect leaders among themselves, setting in motion a process of democratization leading toward a civil society in a country that had witnessed years of tyranny and strife (Kisakye 1996). A hierarchy of representative councils was subsequently established throughout Uganda. Most influential have been the district and sub-county levels, both of which have directly elected their own Local Councils (LCs). Each level also has an administrative head, with a separate line of command.

In 1996, the country was divided into 39 districts in which populations ranged from 17,000 to almost 1,000,000 (Rwabwoogo 1995). The number of districts was increased to 45 in 1997 (Rwabwoogo 1997). There is no intermediate level of administration between the district level and the centre. Each district consists of counties, which in most cases are also electoral constituencies. A county is divided into sub-counties, a sub-county into parishes, and a parish divided into villages, as shown in Fig. 1 (Government of Uganda 1995).

Decentralization

Decentralization reforms involved three main components: political, administrative, and financial decentralization (Villadsen 1996). Political decentralization was based on the Resistance Councils (RCs), later renamed Local Councils (LCs), and was implemented throughout the country immediately after the NRM government was formed in 1986 (Resistance Council and Committees Statute of 1987). Administrative decentralization was gradually introduced from 1993 on with the Local Government Statute (Uganda Gazette 1993), and comprised new administrative structures with a non-subordinated, comprehensive, and judicially

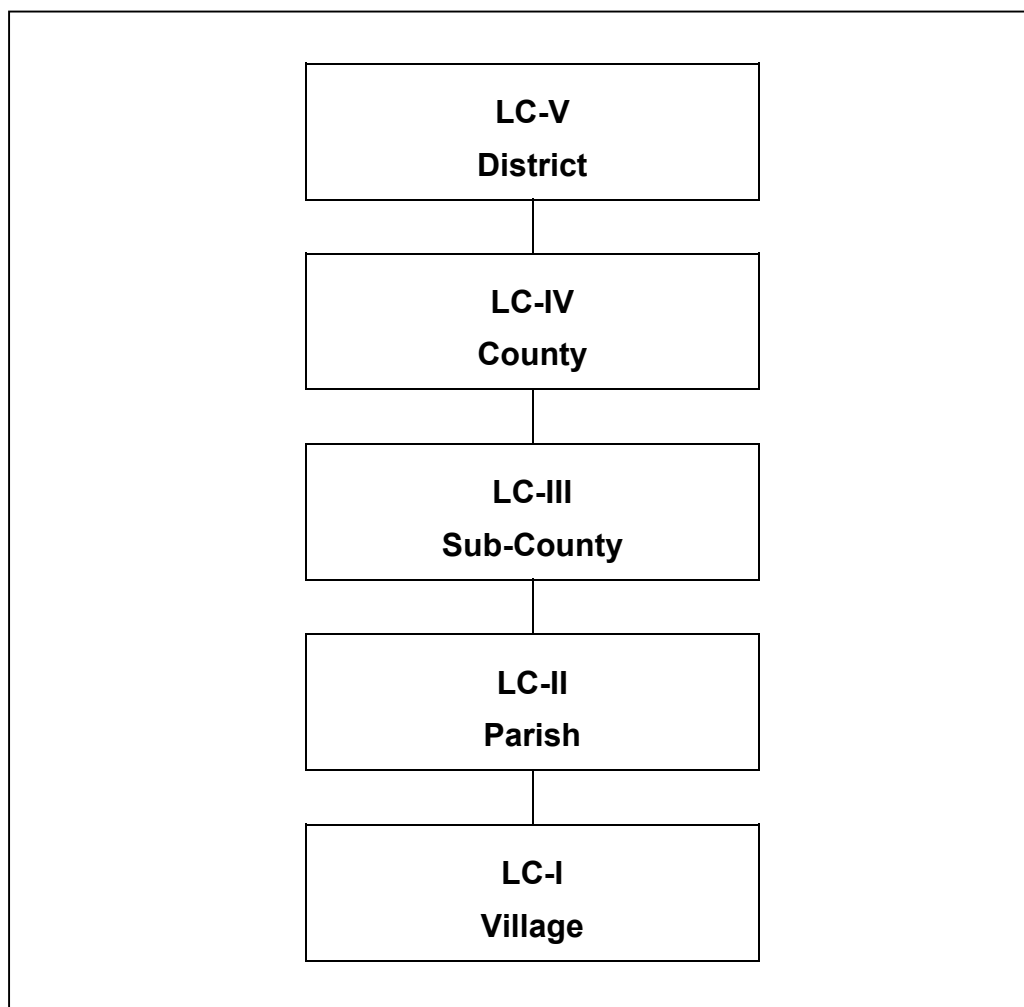


Figure 1. Political and Administrative Levels in a Ugandan District

accountable local administration. Financial decentralization was carried out in phases with the introduction of an unconditional block-grant to each district in conjunction with the introduction of locally-approved budgets. In the Constitution of the Republic of Uganda (1995), the system of local government was further consolidated, and the process continued with the adoption of the Local Governments Act of 1997.

Decentralization has transferred all political and administrative authority from the central government to the local government authorities, including the power to approve district budgets (Kisubi 1996). The function of the central government has thus been directed exclusively to policy formulation, planning, inspection, management of national programmes and projects, security, defence, and foreign policy. The responsibility for the delivery of health services now lies within the districts. The role of the line ministries is to formulate policies and guidelines,

provide technical supervision, set standards, and carry out inspections to ensure appropriate quality. It also includes logistical support as needed.

The major driving force behind decentralization has been the top political leadership, which has seen the devolution of power to lower levels as a counterweight to the previously centralized state. The process has been strongly supported by local politicians and administrators, who have obtained more control over decision-making at the local level.

The civil service, including the MOH, has had very little say in the decentralization process. Having been presented with a *fait accompli* has made it difficult for many civil servants on the central level to accept and support the governmental reforms.

The local government

Whereas technical officers on the district level had considerable say vis-à-vis local political leaders in the old, centralized system, the situation changed with decentralization. In principle, power has been effectively transferred from the technical domain on the central level to the political domain on the district and lower levels. Technical staff are in favour of independence from the centre, but at the same time are not comfortable with their new proximity to local political leaders, all of whom have become very influential. Politicians are unambiguous in favouring the decentralization, as their own autonomy gives them more power over resources at the local level (Lubanga 1998).

Each district government now consists of a District Local Council (LC-V), headed by its directly-elected chairperson, as its legislature, and the Chief Administrative Officer (CAO) and her staff as its executive branch. There is also a Resident District Commissioner (RDC) appointed by the President to handle matters of national importance, such as security, and to monitor the implementation of government programmes and projects. Former central government departments that operated on the district level are now integrated units headed by the LC-V and supervised by the CAO.

Each district has the power to employ, discipline, and dismiss staff through its District Service Commission. However, for purposes of uniformity, the Public Service Standing Orders, issued by the central government, still govern the conditions of service country-wide at the district level.

The central government continues to provide block grants to the districts for services planned for and delivered by the districts. These block grants have replaced a system of earmarked votes determined by the Ministry of Finance. Block grants were introduced in a phased manner and, since fiscal 1996/97, all districts receive them. Several conditional grants have been instituted for specific purposes, such as primary health care. In practice, the allocation of funds to the districts does

not correspond to the actual commitments made by the central government on behalf of the districts. Out of a recurring national budget for fiscal 1998/99, only 34.9% was allocated to the districts. In addition, the relative size of unconditional grants (as compared to conditional) declined from 25.6% of the local budgets in 1996/97 and 26.3% in 1997/98 to 22.8% in 1998/99 (ULAA 1998).

Thus, the central government still has financial power that affects the districts, leaving a considerable discrepancy between the formal powers given to the districts by the Local Government Act and the financial means to exercise them. The local revenue base is also very small, as the lion's share of the income comes from the central government.

Since fiscal 1993/94, the LC-V has become the main budgetary unit in each district, local governments being no longer required to forward their budgets to the central administration for revision and approval. However, thus far only the recurrent expenditure budget had been decentralized during the period studied (1996–2001), with decentralization of the capital or development budget still under discussion.

Applying the definitions of the “public administration approach” (Rondinelli & Cheema 1983), decentralization of the public sector in Uganda can be described as a *devolution*, i.e., a shifting of authority away from the central level of Government to local administrative and political structures of the government. Formal power has thereby been transferred to lower levels in a process that is continuing with the increasing involvement of parish and village level councils in local planning and decision-making.

The districts are responsible for the most expensive services in the social sector, such as health. Tax and revenue collection is generally poor in the districts, with most districts collecting less than 60% of the estimated revenue due. Some politicians have been reluctant to speak out for tax collection, since such activity is not likely to gain them votes. At the policy-making level, however, revenue collected locally is viewed as a prerequisite for the implementation of district services, including health.

Most bilateral and multilateral donor agencies have favoured decentralization as keeping in line with “democratic principles” and other core values. Many have had prior experience with delay and inefficiency in a central government, making them ready to embrace decentralization. A few donor agencies have been more resistant, and have continued supporting traditional vertical programmes with financial control coming from the centre.

Public health

Uganda's economic growth during the 1990s has not been followed by a corresponding overall reduction of mortality or morbidity. The Uganda

Demographic Health Survey of 1995 showed that there have been very insignificant reductions in infant and maternal mortality during the early 1990s. Data from the subsequent Uganda Demographic Health Survey of 2000–2001 suggests even worsening indicators of health status and health service delivery compared to the situation five years earlier. Infant mortality and malaria morbidity are on the increase, and maternal mortality remains constant at a high level, estimated at 506 deaths per 100,000 live births (MOH 2000a). The proportion of fully-immunized children has declined from 47% to 37%, and TT (tetanus toxoid) immunization of pregnant women shows a decline from 54% to 42%.

In 1995/96 a Burden of Disease (BOD) study was carried out in 13 of the 39 districts of Uganda. The unit selected for measuring disease burden was discounted life years (DLYs) lost due to premature death. By this measure it was found that 75% of all DLYs are due to ten preventable diseases, with five of them accounting for approximately 60% of the total burden:

Table 1

CONDITION	%
Perinatal and maternity-related conditions	20.4
Malaria	15.4
Acute Lower Respiratory Tract Infections	10.5
AIDS	9.1
Diarrhoea	8.4
Total	63.8

Among the conditions responsible for the remaining share of morbidity and mortality are tuberculosis, malnutrition, anaemia, intestinal infestations, trauma/accidents, skin infections, mental health disorders, and cardiovascular diseases. As apparent from the statistics above, women and children bear an excessively high proportion of the burden of ill health. Half of all maternal deaths occur at home or on the way to a health care facility and are mainly due to ruptured uterus, haemorrhage, sepsis, or eclampsia—conditions that could easily be prevented or treated successfully if detected early. The majority of the women who die are between 15 and 24 years old. Although two-thirds of the country's pregnant women attend antenatal care at least once, only 38% deliver in health care units. About 10% of all pregnancies develop complications. The infant mortality rate is estimated at 97 infant deaths per 1,000 live births (MOH 2000a), most of which are due to malaria, diarrhoea, pneumonia, malnutrition, and immunisable diseases

(MOH 2000a) for which preventive strategies or effective treatment is available. HIV has emerged as a major threat to public health, although its incidence seems to be decreasing at the present time.

Health care structure

At the time of Independence in 1962, health services in Uganda were the responsibility of both the MOH and the local authorities. Planning, budgeting, and providing social services have become the sole responsibility of districts since decentralization (Villadsen 1996). Only hospitals providing referral and medical training remain the responsibility of the MOH. Public sector reforms have changed the roles of the technical ministries at the central level (Langseth 1996a), including the MOH. Today the main role of a ministry is to develop policies and guidelines within its respective sector, monitor activities, and provide logistical support where necessary (MOH 1999c). In the case of the MOH, the shift of roles has been described as a change from a 'ministry for hospital services' to a 'ministry for health policy development' (World Bank 1994).

The decentralization of the health sector is an integral part of the Ugandan government's reforms. The political body governing the health sector of a district is the District Health Committee (DHC), whose members drawn from the LC-V. Non-hospital-based care is headed by the District Director for Health Services (DDHS), previously known as the District Medical Officer (DMO). The DDHS reports to the Chief Administrative Officer (CAO), who is the civil servant in charge of the whole district administration. The DDHS is assisted by the District Health Management Team (DHMT), comprising technical officers in that office. Since fiscal 1998/99, the management responsibilities of district hospitals have also all been transferred to the districts under the DDHSs. Regional and national hospitals, however, are still under the MOH, awaiting a decision on their managerial structure.

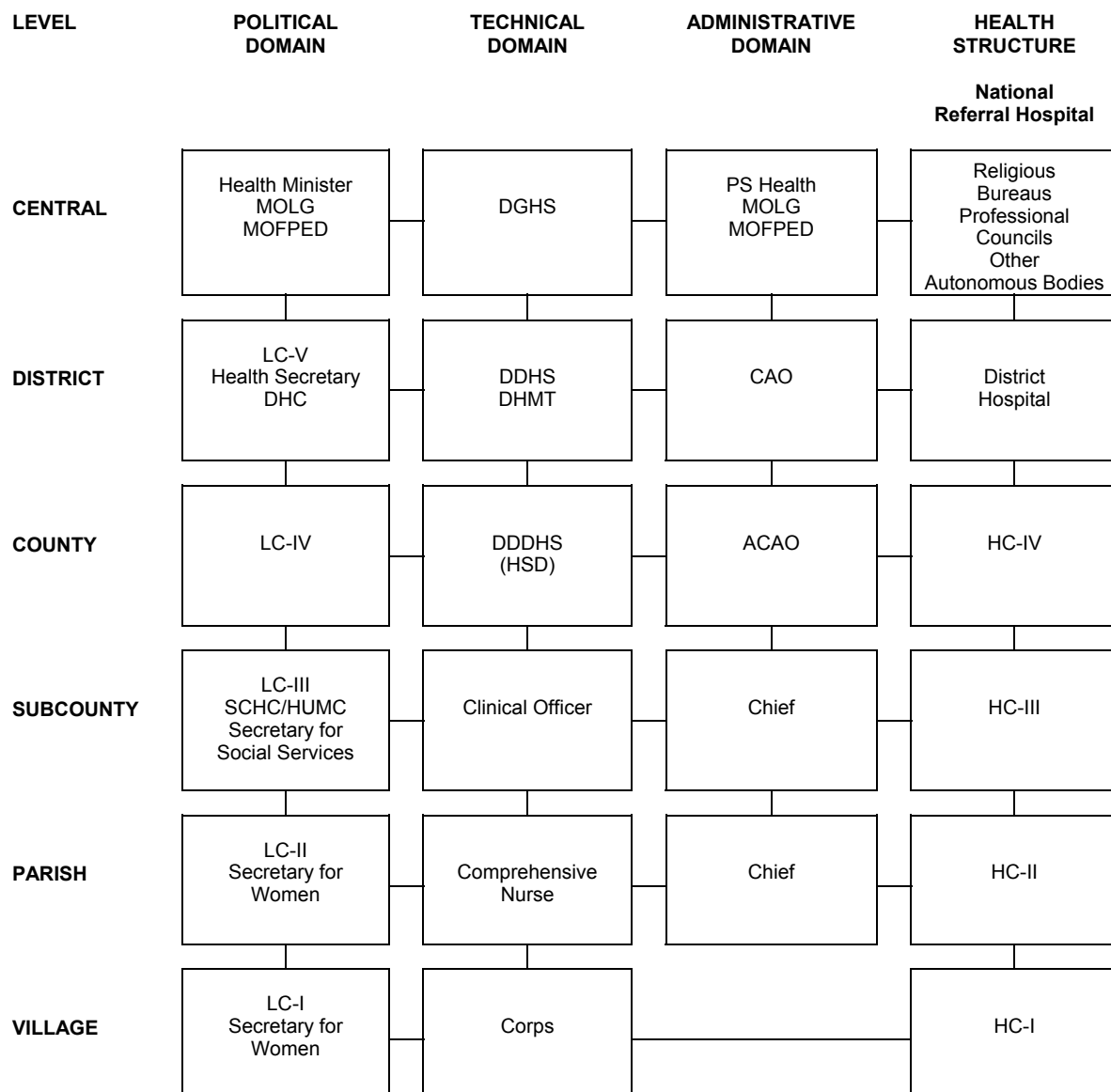


Figure 2. Network of Key Officials in the Health Sector

A number of reforms have taken place in line with the decentralization policy in the last five years. They are aimed at establishing a single, coordinated, comprehensive district health system. The LC-Vs now have the responsibility of providing health services to their local area residents, and whoever provides health services in the district does so on behalf of the LC-V. It is the responsibility of the DDHS to insure that all health care is coordinated and providers are supported.

A recent development is the introduction of Health Sub-Districts (HSDs). These are functional zones within the district health system, established around an existing hospital or Health Centre IV, the lowest unit to employ staff physicians, and the lowest unit to offer elective surgery to its catchment population. The purpose of establishing HSDs is to bring qualified health care closer to the people. However, the management structures at the HSD level remain unclear and are at present supported by no central guidelines.

Sub-County Local Councils (LC-IIIs) have been established and are operational in all districts. The planning capacity of sub-counties in different districts (and even within one district) varies greatly. There are also large regional variations in the status of health infrastructure and staffing patterns. The more affluent regions are found in and around the capital of Kampala, whereas the northeastern part of the country is least developed. On average only 49% of all households live within five kilometres walking distance of a health care facility, but this number ranges from 9% in Kitgum to almost 100% in Kampala (MOH 2001). Most sub-counties have at least one health care unit, but only about 43% of the parishes in the country have a health facility within their boundaries. The infrastructure at most peripheral health facilities is in a deplorable state. Equipment that is in proper working condition is usually minimal, and essential drug supplies are not adequately managed. In addition, safe water is often not available at the health units.

In practice, health facility staffing does not meet established standards. A study in 1999 indicated that only 34% of the existing positions were filled by qualified staff. In general, Health Centres II to IV have no access to electricity, but depend primarily on firewood, charcoal, kerosene, or gas to meet their energy requirements for lighting, sterilization, and refrigeration of vaccines. District and referral hospitals, on the other hand, are usually connected to the country's main electrical grid or have generators to supply their needs (MOH & WHO 1996).

Consequences of decentralization for the health sector

With the shift of managerial responsibility, the recruitment, disciplining, and dismissal of staff are now the task of a body within the respective districts, the District Service Commission. Previously, the central MOH was responsible for deployment of health sector staff to the districts. Despite the fact that the ministry

possessed an overview of the country's needs, the distribution of staff was very uneven, and peripheral districts went largely understaffed. With decentralization, on the other hand, posts are now advertised and districts seek out officers by a recruitment process. However, the inequity between peripheral and central districts remains a major problem.

Theoretical framework

Since the traditional hierarchical steering methods (Lundquist 1987) of organizations have become obsolete, the process of decentralization calls for a more efficient mechanism for implementing policy goals throughout a decentralized system in which the balance between direct and indirect steering has changed. *Direct steering* occurs when A communicates what she intends B to do; *indirect steering* takes place when A affects B's *understanding, ability, or willingness* to take action (Lundquist 1987). A hierarchical structure relies for the most part on direct steering methods; a decentralized one promotes an indirect approach. However, the two types of steering are analytical concepts that appear in combination in real life.

Two other aspects of steering are useful for our analysis: *reliability*, how far the implementer acts in accordance with the decision-maker's steering, and *rationality*, the degree to which objectives are actually achieved (Lundquist 1987, p.181).

When it comes to implementation, the scientific literature (Hjern & Porter 1981; Hjern 1983) traditionally distinguishes between two perspectives: top-down and bottom-up. The top-down perspective envisions decisions made at the top of an organization, followed by a chain of steering down through the organization. Every link of this chain is seen as steering the following one, although the reliability of the steering may be limited. The bottom-up perspective begins where a benefit is received by the person a public organization serves. The difference between the two perspectives can be illustrated by their views on laws and regulations. In the top-down perspective, the law is the starting point for the analysis. The research issue is to explain how laws are implemented. In the bottom-up perspective, the issue of whether the law has any steering function at all is an empirical one. While the top-down perspective focuses on the intentions of the decision-makers, the bottom-up perspective concentrates on the actions of the implementers (Sabatier 1986).

The perspective applied in this thesis can be described as a synthesis. Although I was based in the MOH, my counterparts were also the district officials in the health sector, and so I spent considerable time at the implementation level. My quest was to try to answer the question: "Why don't things always turn out the way we (the decision-makers) want them to?" I focused on the intentions of policy and reform implementation at the central level, which is closely related to a top-down perspective, but also various factors affecting the implementation on a peripheral level, which is more linked to a bottom-up perspective.

The papers collected in the thesis address the prerequisites of policy implementation in a decentralized system. The final paper (V) assesses the outcome of a full-scale policy implementation trial and interprets it against the background of the previous studies. The concepts of diffusion and translation from political

science and policy analysis are applied as instruments in this examination (Jönsson 2002, Johnson 2003).

The spread of new ideas and skills have been characterized by early theorists in this area of research as *diffusion*, a concept imported from the natural sciences (Rogers 1995). An example of diffusion in this sense is when a substance dissolved in a liquid disperses itself into another liquid of the same kind that contains a lower concentration of the substance in question. In the 1920s, European anthropologists began using this concept to describe how innovations are disseminated in different cultures. In the area of policy analysis, diffusion was first discussed by Walker (1969) and Gray (1973).

Later theorists, such as the philosopher and anthropologist, Latour (1986), and the founders of the theoretical school named *new institutionalism in organizational theory* (e.g., Meyer & Rowan 1977), have criticized such models for being too simplistic. The proponents of this school point to the need for a better understanding of the mechanisms of the diffusion process, since diffusion of ideas rarely takes place in a medium as homogeneous as a liquid. On the contrary, the diffusion of ideas usually takes place through organizational structures of a rather complex nature. Such structures contain components and agents conditioned by a heterogeneous set of aims when they encounter new ideas. The result is that such ideas will be viewed in very different contexts, and may often come into conflict with each other. They may, in turn, also initiate a negotiation stage, the *translation* process (Latour 1986).

Latour proposed a process of social interpretation based on the notion that social facts have no independent meaning outside the context in which they are expressed. In the translation perspective it is stressed that social actors are engaged in an ongoing process that perpetually generates and regenerates society. A fundamental prerequisite is that preferences, norms, perceptions, and alternative actions are being constantly formed and discovered in institutional contexts, and cannot be separated from these.

Policy translation can be looked upon as a process of social definition and interpretation, whereby the different meanings attributed to a policy affect its transformation. In this context, it is important to show how and of what elements a policy has been constructed. The translation perspective deals not only with the interpretation of old meanings, but the creation of new ones as well (Hacking 2000, Johnson 2003). Thus, we may define policy translation as “a process where meaning is constructed by temporally and spatially disembedding policy ideas from their previous context and using them as models for change in a new context” (Johnson 2003:239f).

Typical issues in the translation perspective concern the types of ideas that are disseminated, what happens when ideas move into organizations, and what happens to organizations as they receive and incorporate foreign ideas.

Translation is not a definitive event to be carried out once and for all; rather, is it an open-ended one that can be continuously repeated and reinterpreted, as well as

encountered, by intertwined and complex societal processes. While in the case of diffusion the substantive content remains inert and unaffected, translation implies an impact on the content.

The diffusion perspective may suffice when the different contexts are similar, or when there is a consensus on how policy ideas are to be interpreted. However, the translation perspective may be needed in contexts that significantly differ from those in which they have been in use earlier. A diffusion model may exist in a power vacuum, but the translation perspective is always related to power relations in society. Such power relations are seen as perpetual processes (Foucault 1978) that continually develop and change over time.

The focus of the papers in this thesis is on the translation process of central elements in modern health policies when implemented at all levels of a public health system in a particular country—in this case, Uganda. It studies the hypothesized conflict between a technical rationality, and one dictated by the need for accountability on the part of managers and staff at peripheral levels with regard to any sweeping changes in the health care system.

In studies of health policy diffusion it has been questioned whether the implementation of such policies could really be understood solely from the viewpoint of efficiency. On the contrary, focusing more on the *translation* process, where different types of rationalities confront each other, often seems to provide a better frame of reference for studying the process (Jönsson 2002). Accordingly, besides the technical aspects of rationality, I hypothesize that *accountability rationality* would be an important factor in the translation process of a new health policy, especially at peripheral level. This applies to the agents in this process, represented by the leadership and personnel in the peripheral health care system, as well as the target population of their services.

My focus is on the formulation, or, as the case may be, reformulation of policies on the national level, and then on their implementation at the health services delivery level. Implementation problems are often seen as technical problems rather than theoretical ones. In some cases this could, in fact, be a relevant and constructive approach. However, my impression was also that something may be wrong with a causal theory in its implication that rational decisions would necessarily result in rational outcomes and, finally, in rational impacts. My hypothesis would, therefore, be that failure to implement a health policy or a health sector reform could just as well be grounded in an inappropriate causal theory. In order to elucidate the substantive content and the limitations of the problem, the following model can be drawn (figure 3).

In this model, the ability or inability to implement the formulated policy becomes the problem. It is also a question of to what extent lay people can control the system from the bottom up. The decentralization of the public sector provides ample opportunities for the local population to control government in their area through elected representatives. The old system of a centralized public sector was steered from the top down, with little if any influence from those people,

politicians, or civil servants at the implementation level. By contrast, the new decentralized system calls for a more indirect steering, with policies as a key instrument. Nevertheless, the strategies of participation and popular power are not yet fully defined. This issue will be dealt with below, particularly in Paper II.

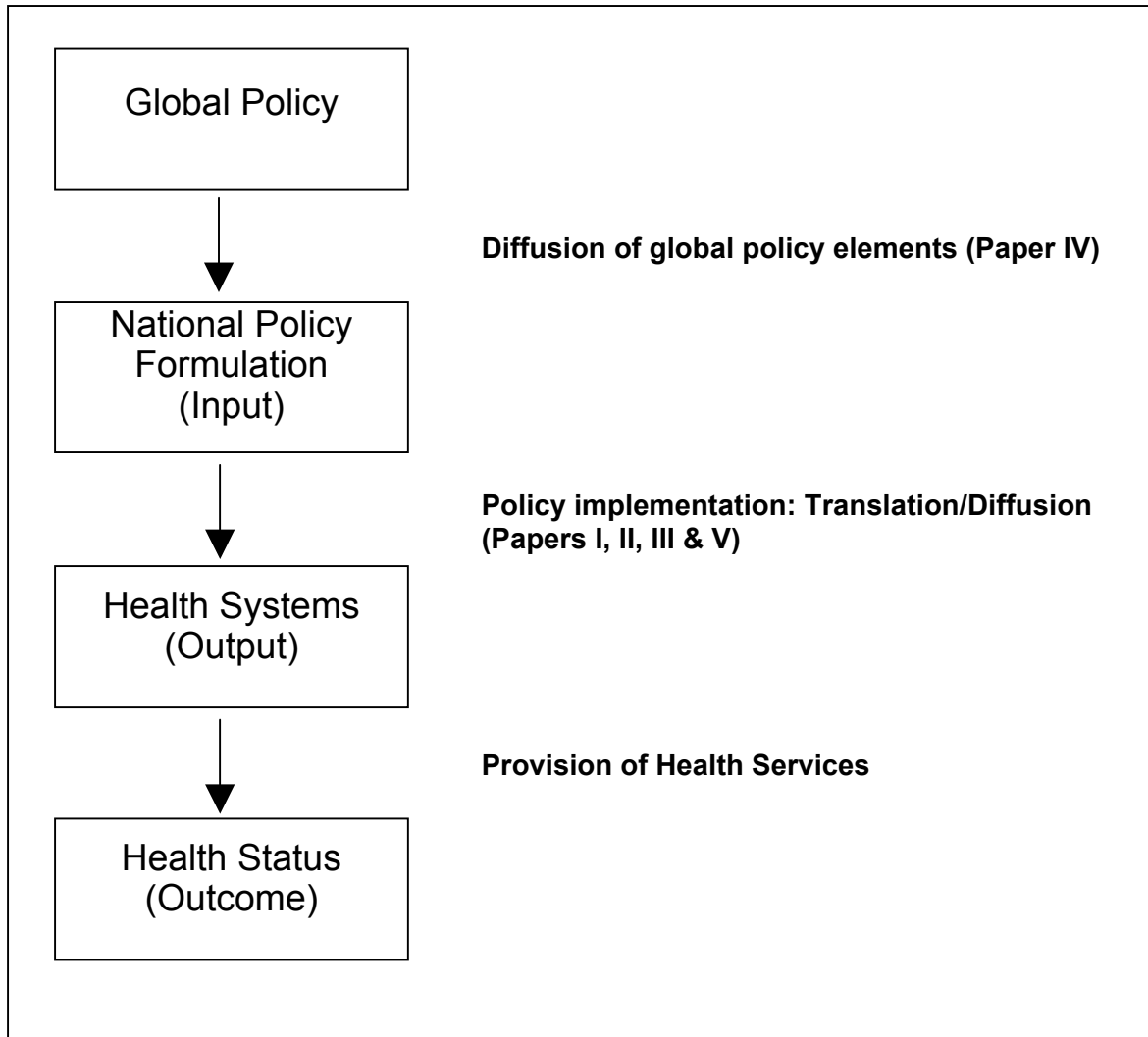


Figure 3. Theoretical model

General methods

I came to Uganda in 1996 as an advisor to the Ministry of Health and remained there, in various capacities, until 2002. This thesis deals with my experiences during that six-year period, during which I interacted with many people at the national and the district level. They all had different designations, but were all assigned the task of delivering health services. As the implementation of health reforms largely took place in the districts, continuous interaction with the people at the local level was a *sine qua non*. In the research community, this approach or working method could probably best be described as participatory observation (Fetterman 1991). It implies that the researcher not only observe the people being studied, but participate in their activities (Borofsky 1994). I was directly involved in the implementation of health reforms, not just an observer. Through my work, I became part of the Ugandan community and was, in fact, adopted by the Karimojong people. The anthropologist's task is to observe, record, and analyze a culture, interpreting signs and symbols to understand their meaning within the culture itself. This interpretation should be based on the "thick description" (Geertz 1973) of a sign to see all potential meanings. While my own personal experiences constituted the nexus tying the experiences together, various other methods were used to gain in-depth knowledge in certain areas.

The MOH, and in particular the Projects Coordination Office (PCO) of the World Bank (WB) projects in the health sector, was where I worked most of the time. It was a very fertile ground for information and discussion. All districts were beneficiaries of the projects, and visitors holding different positions from all over the country paid frequent visits to our office in the MOH. We visited all the districts regularly, as well. The interaction was close, not only with health workers and managers in the districts, but also with administrators and political leaders from the peripheral up to the cabinet level. In addition, contact with the rest of the MOH was very intense. Formally, the PCO was part of the Health Planning Department (HPD) and was the hub of most activities in the MOH, especially before restructuring was undertaken and the SWAP process was not yet in full swing. The PCO played an influential role in health planning and was also actively working to revitalize the HPD during the reforms. The collaboration with the Decentralization Secretariat of the Ministry of Local Government, a unit instrumental in capacity-building parallel to the decentralization of government, was also very close, as was collaboration with the Ministry of Finance and Planning (MOFPED). In this environment, data was abundant and easily accessible.

Incorporating an anthropological perspective also has implications for the overall analysis, be it of a tribe, a village, or a ministry. Anthropology uses cultural differences as a cultural critique and enrichment (Borofsky 1994). It stresses that

possibilities beyond those we are familiar with exist for solving problems and achieving meaningful lives. Furthermore, it stresses that those on the margin—the subjugated and the disempowered— may also have an important contribution to make to others (including those at the centre of power). The disadvantages of using anthropological methods manifest themselves in comparing data and generating commensurate information. Anthropological data are mainly qualitative, which rules out statistical analyses. Quantitative studies, however, may be incorporated as part of a larger qualitative study. Anthropological studies generally require considerable time for their preparation and follow-up (Keesing 1981), and are mostly limited to a specific, circumscribed area. Although this study has been carried out in a low-income country in Africa, it is my belief that the results may be of relevance not only in similar African contexts, but in more affluent parts of the world as well.

Specific methods

The intention here has been to use as simple and few methods as possible for the analysis. However, the complexity of the society and objects of study require a corresponding degree of methodological sophistication, if a nuanced analysis is to result. The methodologies, according to the five papers in which they are employed, are outlined in table 2.

Table 2

Overview of Methodologies					
Paper number	I	II	III	IV	V
Method of data collection	a. Interviews with district officials b. Compilation of data available at MOH (district budgets) c. Focus group discussions with district officials	Observation, participation in meetings at central and local level, interaction with central and local government officials, donor and NGO representatives, interviews, review of documents available at MOH	Observation, participation in meetings at central and local level, interaction with central and local government officials, donor and NGO representatives, interviews, review of documents available at MOH	Observation, participation in meetings, interaction with central and local government officials, donor and NGO representatives, interviews, review of documents available at MOH	a. Compilation of data available at MOH (district budgets) b. Compilation of data available in the districts (financial reports) c. Structured interviews
When were the data collected?	d. 1996–1999 e. 1996–1998 f. August–September 1999	April 1998–May 2002	1997–1999	1996–2002	d. 1996–1999 e. 1998–1999 f. 1998–2001
How were the data recorded?	g. Written notes h. Compilation of data on spreadsheets i. Written notes	Written notes	Written notes	Written notes Compilation of data from documents available at MOH	a. Compilation of spreadsheets b. Compilation of spreadsheets c. Questionnaires
How were the data analyzed?	j. Interview analysis k. Face value in tables l. Interview analysis	Interview analysis	Interview analysis	Interview analysis	a. Face value in tables b. Face value in tables c. Interview analysis

Analysis of interviews

In order to analyse the interviews, a few different approaches and techniques were used, depending on the content of the interview material, as well as the particular context. Initially, interviews were generally conducted until substantive saturation was achieved, i.e., when no (or negligible) additional information was forthcoming. The interviews were all conducted in English. As with all data used in this thesis, the load was extensive and had to be concentrated in order to retrieve the most exact meaning. This required shaping the data into broad categories. In one case (Paper V), some categories were further broken down into quantifiable entities. The approaches used in this thesis are all based on hermeneutical or phenomenological philosophy (Kvale 1996).

Paper I

Financial priorities under decentralization in Uganda

When the power to approve district budgets was transferred from the national to the district level, the Ministry of Finance made a shadow budget for the fiscal year 1995/96 as a reference point from which to monitor priorities and allocations made by the districts. The shadow budget was a theoretical construct equivalent to the budget of the previous fiscal year.

The district allocations for health in the 39 districts was studied by systematically retrieving data from the annual workplans the HPD of the MOH reviewed in order to provide feedback to the districts on technical issues. The same plans were also submitted to and partly financed by the WB projects in the MOH. They could consequently be studied systematically and compared to the situation before the decentralization of finances took place. The general assumption was that the districts, in their allocations, would financially prioritize health in order to implement the national health policy.

In this study, all district plans and budgets were compiled, providing data for the initial phase of the study, which addressed the question of *how much* was allocated for public health. To investigate the subsequent *why* question (the reasons for deviations from the shadow budget), senior civil servants and politicians in the districts were systematically interviewed during visits by a team from MOH (including myself) over a period of three years. A series of open-ended questions were posed and written notes were taken. Most districts were visited several times, but in a few cases rebel attacks, civil unrest, attacks by foreign powers, and Ebola outbreaks made further visits impossible, although attempts were made.

During each visit to the districts, a protocol was followed whereby the CAO (or the Deputy CAO or Assistant CAO), District Local Council Chairperson, and later also the Secretary for Health in the district were visited. When these officials were not unavailable, appointments were made with their designees. At each district visit, the issue of priorities in budget allocations was discussed. The Resident District Commissioners (RDCs), who represented the central government in the districts, were also interviewed in a number of districts. The arguments presented were systematically noted down and analyzed until it was felt that saturation was achieved, with no new arguments forthcoming. Statements were concentrated and common themes sought. The results were fed back into the interview questionnaire and the questions were made more precise over time.

To obtain further information from district leaders, three focus group discussions were held in August and September 1999 with mixed groups of administrators and politicians representing 14 districts (Asbury 1995; Krueger 1988; Ramirez & Shepperd; 1988 Morgan 1997; Krueger1997a; Krueger1997b)

These discussions were carried out in Masaka, Mbarara, and Jinja, and the groups consisted of 15, 8, and 6 individuals respectively from different parts of the country. The interviewees were participants in regional conferences on health planning and included senior district politicians and administrators who, in most cases, were responsible for the health services in their districts. Health professionals were excluded from the focus groups since the purpose was to extract the views of politicians and administrators. The most common arguments heard were written down, and the views of the politicians and administrators were analyzed separately, but were not quantified. The arguments presented were condensed and classified according to themes. Gradually, a saturation of arguments was achieved; few new arguments were heard in the final focus group discussion, and it was deemed unlikely that further discussion would generate additional information. The data analysis characterized above could be referred to as concentration of meaning.

Interviews were also held with officials strategically selected from the Ministry of Finance (to obtain data on the shadow budget), and the Decentralization Secretariat of the MOLG (to acquire information on the rationale governing the overall budgeting priorities in the districts). These interviews were analyzed in a way similar to those carried out in the districts.

Paper II

SWAP dynamics in a decentralized context: experiences from Uganda

As the planning and coordination function of the MOH was weak, donors generally interacted directly with the technical programmes, departments, and units in the MOH. Some donors also provided support, either directly or through the MOH, to a limited number of districts. This complicated state of affairs initiated discussions that led to the Sector-Wide Approach (SWAP) to public health.

SWAPs address whole sectors rather than specific activities or projects (Peters & Chao 1998), and relies on government procedures to disburse and account for all funds (Foster et al. 2000).

The initiative to introduce SWAP in the Ugandan health sector has mainly come from large donors (Pavignani & Durao 1999). This paper examines how the SWAP process affects power relations in the health sector, and particularly the relationship between the central and the peripheral levels.

This analysis is a result of closely studying and participating in the SWAP process from its inception. The discussions on moving from detailed project support to general budget support originated from the WB projects in the MOH. The purpose of these projects was both to build capacity to deliver health services and to facilitate health sector reform and policy formulation. SWAP was a logical continuation of these activities. In 1998, the MOH, with support from the WB and WHO, invited international agencies and other stakeholders to a meeting in Kampala to discuss the implications of SWAP. The meeting took place and was documented in writing, and the official minutes have been reviewed. From 1999 onwards, regular Joint Review Missions (JRMs), with participation from governmental and international agencies, NGOs, and other stakeholders, have been held twice a year. During these missions, the development of SWAP was debated, along with the formulation of a new national health policy, strategic health plan, and a variety of related issues. As a participant, I was in a position to record the proceedings, taking special note of how different stakeholders presented different arguments. The raw data were reviewed and organized into broad categories by type of argument and stakeholder. The categories that emerged facilitated the identification of different interests and made it possible to follow developments over time.

Table 3

Joint Review Missions (JRMs) on the Health Sector SWAP in Uganda until April 2002:

1 st JRM	28–29 October 1999
2 nd JRM	10–14 April 2000
3 rd JRM	25–27 October 2002
4 th JRM	02–06 April 2001
5 th JRM	15–19 October 2001
6 th JRM	15–19 April 2002

I took part in all the missions, including plenary sessions and group work, until April 2002. The Aide-Memoires, i.e., the official JRM minutes, show the gradual shaping of Uganda's health sector SWAP. Between the missions, the SWAP process was institutionalized through a committee, the Health Policy Implementation Committee (HPIC), whose members included representatives from the MOH and the main donors. The chair was the Director General of MOH. The committee, later renamed the Health Policy Advisory Committee (HPAC), initially met every week. I also attended some of the committee's meetings, and was able to review its minutes for the period I spent in Uganda. I was also a member of two working groups under HPAC (Decentralization and Public-Private Partnership). Again, I was able to document these meetings in writing.

The data obtained in this study were analyzed with reference to the effect the process had on power relations. It was assumed that, consciously or not, the various groups taking part represented different power interests (Foucault 1978), and so expressions, documents, speeches, and actions were analyzed according to whose interests were being explicitly or implicitly favoured.

Paper III

Restructuring a Ministry of Health: an issue of structure and process

As a part of the civil service reform in Uganda, all the national ministries were to be reduced in size to improve efficiency. Most ministries had grown so large since the time of Independence that their efficiency had been reduced (Langseth 1996a; Government of Uganda 1990). In restructuring the government, the task was to create a civil service with clear organizational mandates and objectives. Some of the new guiding principles were transparency, results-orientation, implementation of simplified rules and procedures, and the allocation of resources and budgeting based on clearly identified priorities. The civil service was to be smaller and its employees better paid (GOU 1993).

In general, officials at the MOH were still functioning as in the past, i.e., managing vertically-organized programmes from the central to the local level. Districts at this time were becoming increasingly aware of their new powers; local administrations no longer tolerated interference by the central government in their day-to-day operations. In 1997 it had become clear that it was necessary to embark on a restructuring of the MOH, an exercise that was to continue until mid-1999.

Facilitating the restructuring of the MOH was one of the major tasks assigned to the WB projects within the MOH, where I was working at the time. My position facilitated the close study of the restructuring of the MOH. In this study, data has been collected a) through an intensive series of meetings in the MOH called by the consultants who proposed the new organizational structure in December 1997–January 1998, b) by interviews with civil servants inside and outside the MOH, and c) by interviews with donor representatives. A number of official documents were studied, including the report of the 1995 restructuring exercise, the Constitution, and the 1997 Local Governments Act.

During Phase I of the restructuring exercise, which lasted from 3–15 December 1997, I worked closely with the government's consultants and attended the initial meetings with the HPD, the body responsible for consultation within the MOH. On 12 December 1997, a session was held in which the senior management group of MOH was to examine the mission, objectives, and output of the MOH. These meetings were documented in writing, reviewed, and categorized by stakeholder. Further, a review of documents produced by the consultants, the MOH, other ministries, and donor agencies was carried out (GOU 1990, GOU 1993, MOH 1995, MOH 1998a, MOH 1998b, MOH 1998c, MOH 1999, WB 1994a).

Phase II lasted from 5–30 January 1998, and involved a broader section of participants—not only from the central MOH, but from hospitals, donors, and NGOs as well. On 8 January, a large group of senior management officials attended a workshop to discuss how to proceed. During the following weeks a number of

meetings were held at the MOH on the same topic, with donor agencies also involved in the discussions. At issue were the consultants' proposals and the presentation of a final report on the restructuring. Once again, I attended and documented all of the sessions in writing. Discussions were also held with a large number of district officials during field trips to different parts of Uganda, and these discussions were also documented in writing.

In analyzing my written notes, I attempted to organize statements according to narrative stories told by different types of stakeholders (technical officers at the district level, health planning officers at the MOH, top management officials at the MOH, and others). The idea was to visualize their different lines of reasoning.

Paper IV

The global/local dilemma of a Ministry of Health: a case study from Uganda

The development of a new national health policy for Uganda for the period from 1999 to 2009 began in 1996; the policy was approved by the cabinet in 1999. The new policy signifies a transition from emergency relief operations within the health sector to a social development perspective on health (Ministry of Health 1999a).

This paper is based on participatory observations while at the MOH. My work was conducted centrally as well as in the districts. I took an active part in a series of meetings related to policy formulation—from the Annual Health Review of the Quality Assurance Programme of the MOH in November 1996 (when discussion began on a new national health policy), to meetings on policy implementation, SWAP, Public-Private Partnership, and other key issues over the course of several years related to health sector reforms and to the new national health policy. Some of these meetings were organized by temporary task forces. Others had a more regular structure and long-term mandates. Again, one of my key tasks remained to act as a facilitator in the process of health sector reform, especially in matters related to a decentralized health care system.

Interviews were held with key officials inside and outside the MOH, as well as with donor representatives. Further, reviews of documents produced by the MOH (MOH 1995, MOH Ethiopia 1996, MOH 1996a, MOH 1996b, MOH 1998a, 1998b, MOH 1998c, MOH 1999a, MOH 1999b, MOH 1999c, MOH 2000a, MOH 2000b, MOH 2000c, MOH 2000d), other ministries (MOFPED 1998), donor agencies, and representatives of NGOs were conducted (WB 1994a, WB 1994b, WHO 1999, WHO & MOH 1998). Interviews were also held with a large number of district officials during field trips throughout Uganda. As stated earlier, all districts were visited at least once, and most were visited several times.

Extensive studies were conducted of the health budget at the central and at district levels, as well as of actual expenditures. Information on both of these matters was obtained from the MOH as well as from the MOFPED. While the district budgets were available at the MOH, determining actual expenditures required travelling to the districts, and in most cases also assistance from auditors. As part of my assigned duties, I reviewed all of the annual district workplans, which also contained the respective budgets. A review was also specifically carried out regarding documents on the Essential Drugs Programme in Uganda (Adome et al. 1996, McPake et al. 1998, Danish Red Cross 1999).

All interviews were open-ended, and were initially composed of rather broad questions. Gradually, a saturation of data appeared, usually after asking the same

questions about three times. New issues that arose were included in the questionnaire, sharpening its focus.

Paper V

Application of Burden of Disease/Cost-Effectiveness Analysis as an instrument for district health planning: experiences from Uganda

The application of normative rationalist instruments such as BOD in combination with CE was studied. It was assumed that these instruments would facilitate the implementation of national health policy priorities at the district level. This study follows a three-level methodology.

Firstly, the outcome of the BOD/CE study was examined. Budgeting for each programme area was investigated in all 13 districts that participated in the BOD. The baseline was the budget for fiscal 1995/96—the year when the exercise was carried out. A concrete budget had been made prior to the actual study. The budget allocation pattern in 1995/96 was compared with the pattern suggested by the BOD and patterns in the subsequent budgets for fiscal 1996/97, 1997/98, and 1998/99 in all the districts concerned. Districts were required to make detailed annual workplans and draw up budgets for the health sector, and these budgets were obtained from the districts by the MOH. The data gathered in this way was accepted at face value and analyzed numerically.

Secondly, a comparison was made between 13 district budgets and *actual expenditures* for fiscal 1997/98 to find out whether actual expenditures reflected budget allocations by programme area. These expenditures were retrieved from the financial reports made in the districts, and were only available at the district level. Hence, gathering this information required once again visiting the districts. A comparison with previous budgets and the BOD patterns suggested by the BOD/CE analysis was then made.

Thirdly, the process of the BOD/CE study was examined. DMOs and other officials from the 13 districts that participated in the BOD study and in district planning were interviewed, one person per district being selected. The interview followed a structured questionnaire (Berdie 1986). All interviewees had been trained previously in the BOD/CE methodology in Kampala. They had also been actively involved in applying BOD/CE as a method for planning and budgeting in their districts. Interviews were undertaken in the districts, and a few in Entebbe and Kampala. Security issues sometimes made the process difficult, but in the end all interviews were completed, although in some cases this took over two years. The objectives of the structured interviews were to determine how district health staff viewed their own understanding of BOD/CE, and assess their view on its usefulness for health planning and budgeting at the district level. Respondents were individually questioned as to their understanding of the BOD/CE concept, to what extent it had influenced their way of thinking about health planning and budget allocation, and in what measure it had affected the actual practice of health

planning and budget allocation. They were then asked in greater detail about the way they carried out health planning before and after undergoing training in BOD/CE. Finally, they were asked about their views on the usefulness and limitations of BOD/CE as a concept for health planning. This analysis permitted the establishment of broad categories and allowed simple quantitative analysis.

Ethical clearance

The MOH of the Government of Uganda has given its explicit permission to publish this thesis and the papers upon which it is founded. Discussions have been held with the Committee for Research Ethics of the Medical Faculty at Lund University, and its chairman has stated no objection to the research carried out and the publication and presentation of this thesis. Discussions have also been held with the Research Education Committee of the Medical Faculty of Lund University, and its chairman has granted his approval to the presentation of the research in this thesis.

Results

Paper I: Outcome

Financial priorities under decentralization in Uganda

The actual allocation for primary health care fiscal 1996/97 came as a surprise to the MOH. While the shadow budget made by the MOFPED (established at 1996/95 levels) projected that overall 4 billion Ugandan shillings (approximately USD \$3.6 million) would be set aside for primary health care (PHC) in 1996/97, the district administrations only allocated 1.1 billion shillings, or slightly more than one-quarter of the shadow budget. The source of these allocations was the block grant provided by the MOFPED and locally-raised revenues. The pattern differed from one district to another, but the overall amount indicated a considerable discrepancy between the funding anticipated by the MOFPED and the actual allocations by the districts. During fiscal 1997/98 there was an increase in the overall allocation for primary health care by the districts, amounting to up to 2.6 billion shillings (approximately USD \$2.4 million). Although a considerable increase did take place, the actual district allocations were still far from the ones anticipated by the central government.

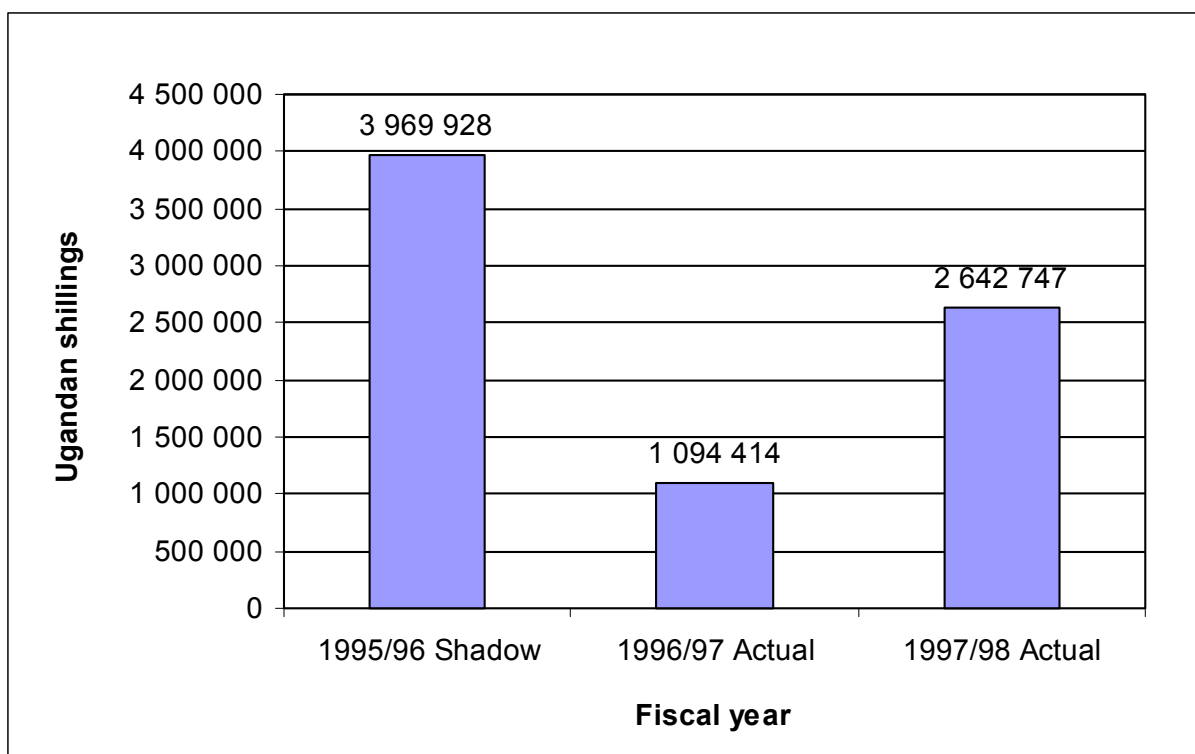


Figure 4. Comparison of actual expenditures vs shadowbudget in the districts

Individual interviews and focus group discussions revealed that priority had been given on the basis of 1) insufficient local revenue, 2) lack of funding from the central government, 3) high expenses, 4) lack of ownership, 5) contributions for other sectors already being received, and 6) the existence of donor funds available for public health.

Paper II: Outcome

SWAP dynamics in a decentralized context: experiences from Uganda

After years of decentralization, with district power increasing vis-à-vis the central level, the SWAP process introduced into the health sector of Uganda once again changed the role of the MOH. The ministry regained much of its former influence, while the districts lost considerable power in the SWAP process. Among the main reasons for this shift of power were the advent of conditional funding, planning arrangements, and the right of veto against donor-district interaction. Most important of all was the power emerging from the negotiation process proper, which is the core of the SWAP process. The MOH played the lead role in this process. Although the districts had been given ample formal power, the MOH and donors were able to gain significant informal influence on all those involved in Uganda's health care policy, including the district health services. After being dormant for a long period, the HPD was gradually reactivated and assigned a central role (Brown 2000).

In order to strengthen the SWAP process, new working arrangements were needed within the MOH as well, and so reorganization of the entire MOH was undertaken. The central planning framework had gradually changed the role of the MOH from promotive and facilitative to prescriptive. The lines of communication had largely been reversed to a vertical, top-down form, leaving the districts with little to say in the SWAP process. The districts were once again obliged to implement the national policy in accordance with the central planning framework developed by the MOH. This framework extends from rather abstract goals at the centre to the concrete activities planned by the districts in their annual work plans.

SWAP puts all funds under the control of a central ministry, a strategy counter-productive to decentralization. The health SWAP negotiation process in Uganda has taken place with donors and the MOH as the two main agents, generally bypassing the districts, which are, nevertheless, responsible for the delivery of services.

The SWAP process is connected to an overall Health Sector Strategic Plan (HSSP) (MOH 2000b), centrally developed with a five-year perspective. In addition, for several years the districts have developed annual work plans for the health sector. This practice is well established and all districts make such operational plans each fiscal year. These plans are expected to be linked in parallel to the national level HSSP through a five-year strategic district health sector plan which, in turn, is supposed to be reconciled with the existing three-year rolling development plan in the district. With SWAP, the role of the MOH has come to include approval of district annual work plans for health. The role of the MOH is to guide the districts and give them feedback on the plans. In line with

decentralization, districts were given a great deal of autonomy in the planning processes, including health policy. The annual district work plans were largely developed without the involvement of the MOH. This decentralized system was still in its infancy when it was subordinated by SWAP.

To date, the construction of public health facilities is a central level responsibility. Several districts and lower levels have, however, chosen to fund the construction of parish (LC-II) health units themselves in order to reduce disparities within the district regarding access to health services. The problem remains that capital investment also implies future operating costs, a financial burden that the district may not be able to bear in the long term. Together with the MOLG, the MOH has decided that sanctions will be put in place against districts where health facilities are constructed using direct funding from the respective districts, unless prior approval has been given by the MOH.

The role of NGOs in the SWAP process has always been ambiguous. In terms of financial support, it seems that mission health facilities will get considerably less support from the government than corresponding government facilities. Through SWAP, the MOH can veto any kind of district support rendered by a donor participating in the SWAP process. This development once again decreases the autonomy of the district. Thus, the MOH has increasingly come to regulate the interaction between districts and donors through the SWAP process.

The justification for SWAP is to simplify the implementation of financial support to the health sector and ensure government ownership. To a large extent, this is what has taken place. But the districts, who are the true implementors, have been assigned a very limited role under SWAP. The democratization process that should follow hand-in-hand with decentralization is thus countermanded by the SWAP process. Remarkably, the two processes are supported in Uganda by the same donors.

Paper III: Outcome

Restructuring a ministry of health: an issue of structure and process

The purpose of restructuring the MOH was to reduce the number of employees and turn the ministry into a more functional body. This was needed, given the changed *modus operandi* expected of it in a new, decentralized context. Simultaneously, the ministry moved from the old, colonial capital of Entebbe to Kampala, an event that had actually been planned since 1956.

The output of the restructuring process was largely a logical consequence of analysis, based on the objectives and broad key functions of newly organized units in the MOH. These units were no longer organized vertically by single entities (ARI, malaria, etc.) but by areas of disease or even broader categories (e.g., child health, maternal health). However, the vertical (technical) programmes still remained more or less within the new, broader units. Staff budgets were reduced by 5%. The overall number of 928 posts was reduced by 69 (mainly support staff). The line of command was reduced at the top, with fewer commissioners (5 instead of 11), assistant commissioners, principal medical officers, and so on. Although the actual reduction of staff was much smaller than expected, the plan was still praised from outside the ministry (especially by the donors) for its efficiency.

After the restructuring, the ministry produced a National Health Policy (1999) and several subsector policies according to the objectives that had been set. The planning process for the health sector was driven by the HPD of the ministry. This department has gained considerable influence inside and outside the ministry, and particularly in the donor community, where it has emerged as their major counterpart.

Much effort has been expended to develop a policy and comprehensive plans for the health sector. What remains problematic, however, is the actual implementation of those policies. The instruments developed by the HPD for implementing health policy entail a series of steps. They were primarily developed by technical officers on the basis of logical framework approaches. The relationship between the ministry and the districts is largely upheld in those instruments, with the districts retaining technical functionaries, rather than political or administrative ones.

Technical support visits to the districts by central officers have become less frequent. Many MOH officials perceive their role to be the initiation of guidelines for technical programmes—something that they feel can be done at the ministry headquarters, without the need to consult district health planners. If the latter must be consulted, district staff can be summoned to headquarters in Kampala. The general opinion at the national level is that the districts have little to contribute to the planning process at the central level. This, in turn, results in a lack of

participation and lack of ownership in subsector policies by the people responsible for their actual implementation.

Further, the finalized technical guidelines have not always been effectively distributed to the implementers. Before organizational restructuring, complaints were often heard about extensive interference in the operation of technical programmes in the districts by the central level. The current complaints are over the lack of interaction, support, and supervision. In fact, restructuring initially led to the virtual dissolution of any relationship between the central and peripheral level, particularly with regard to technical programmes—a fact that was very disturbing to the districts.

There is still a need to develop appropriate interaction between the national MOH and the districts, so that districts may fully participate in the planning process, as well as in the formulation of policies and guidelines. There is a lack of openness and trust in the relationship that blocks a fruitful collaboration between the centre and the periphery.

Paper IV: Outcome

The global/local dilemma of a Ministry of Health: a case study from Uganda

A review of the 1993 Health Policy White Paper and the 1997/98–2006/07 Health Policy shows that both statements are based almost entirely on international concepts from outside the country, such as PHC, decentralization, SWAP, the essential health package, and a public-private mix of health care. It is left for the implementors to translate ideas, paradigms, and policies to better suit the local context.

Ideally, the two parties, international and national, should have equal influence on policy. In practice, the impact of international agencies on policymaking is enormous. These agencies have the technical know-how to develop and support a policy; they can offer funds ready for release if a policy is adopted, and they add important symbolic value. It therefore takes a very strong stand on the part of the government to reject a suggested policy, as room for negotiation in such an instance is very small.

In 1993, the Ugandan government produced a Health Policy White Paper and a three-year Plan Frame 1993–1996 (extended to 1997/98). During this planning period, health policy focused on consolidating existing PHC services and addressing AIDS. From 1998 onwards, the eradication of poverty in the health sector became the priority. The overall policy goal for the current National Health Policy (1999–2009) is the rapid attainment of improved public health for all Ugandans. The policy also strongly reflects the Alma Ata Declaration of Health for All (HFA), the National Health Sector Reform Programme, the Poverty Eradication Action Plan (PEAP), and the Health Sector Poverty Action Plan. In addition, SWAP has rallied those in the health sector around a single policy and the implementation of a single national strategic plan, and the use of a common management system.

Recurring health budget funding on part of the government has gradually increased from 43% in the early 1990s to 63% in 1997/98 (MOH 1999a). International donor agencies are expected to fund the remaining part. The annual per capita expenditure for health, including government and external contributions, is USD \$3.95 (MOH 1999b; MOFPED 1998).

The Uganda Essential Drugs Management Programme (UEDMP), now known as Uganda Essential Drugs Support Programme (UEDSP), was founded in 1985 (Okuonzi & Macrae 1995). Since then, health care has been centered largely on the issue of pharmaceuticals (Danish Red Cross 1999). Considerable funds are invested in pharmaceuticals, tending to make them the focus of the health care system. Drugs have great value on the grey market, and illicit drugs can be purchased in

local shops and stands. Several studies pointed to a wholesale disappearance of drugs from public health facilities (Economic Policy Research Centre et al. 1996, Adome et al. 1996).

Recent health reforms have centered on systemic problems and on capacity-building in key support systems. The system is primarily underwritten by external funding, although administered by largely unmotivated civil servants. This external funding does not generally include the payment of salaries, but only covers a per diem for health staff and travel expenses outside the country. This inadequate compensation is partially offset by bonuses that often attract more attention than the job itself. Since funds are generally not requested from below, but distributed from above, there is only a very limited sense of ownership in the items procured or the infrastructure built. Where there is no participatory involvement on the part of the local community or district leaders, maintaining district programmes becomes a problem, and many of these health facilities soon end up in a deplorable state (Hultberg 1999).

The heavy reliance on external funding unbalances the system and decreases its long-term sustainability. Most foreign officials are only concerned with specific projects, rather than the overall system. The broadest goal of public health policy, namely, the building of a comprehensive and sustainable health care system, receives insufficient attention, while smaller projects or programmes are often over-funded, pursuant to the interests of international donor agencies. Health care is virtually transformed into a biomedical product that is donated to the beneficiaries for their consumption.

Paper V: Outcome

Application of Burden of Disease/Cost-Effectiveness Analysis as an instrument for district health planning: experiences from Uganda

The budget

The budget was carefully examined for all public health programmes in the 13 districts that participated in the BOD study. It became apparent that, in the case of almost all diseases, budget allocations were inversely proportional to the amounts recommended by the BOD.

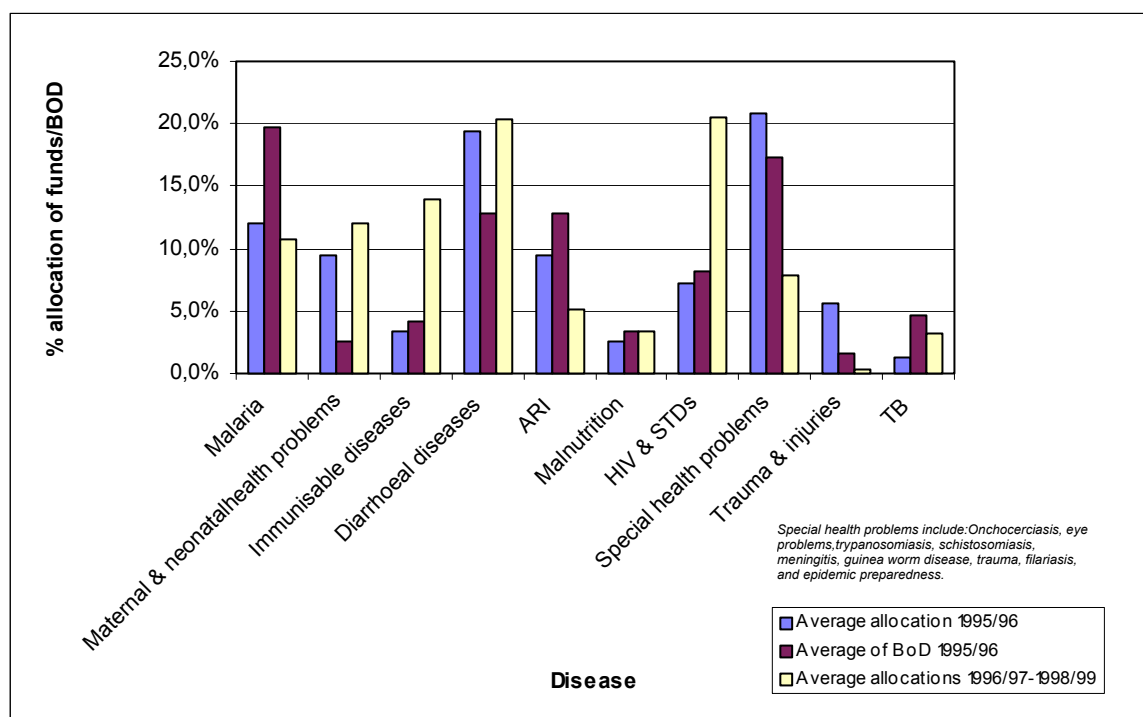


Figure 5. Allocations of funds vs BoD

Malaria activities, for example, were previously extremely underfunded. Instead of increasing, the actual budget allocation later *decreased*, even when the BOD/CE had demonstrated that malaria was the largest single cause of the BOD. One can see similar patterns in the case of ARI.

For maternal and perinatal conditions, initial budget allocations exceeded what would have been consistent with the BOD. But instead of decreasing funds, the

new budget actually increased spending even further. For immunizable diseases and the control of sexually-transmitted diseases (STDs) and AIDS, the BOD/CE suggested a marginal increase in the budget allocation. However, actual budget allocations widely exceeded what was indicated. Only in the area of nutrition was the average budget allocation close to that suggested by the BOD/CE.

Actual expenditures

Actual expenditures by programme area were studied in detail in all the 13 districts for the fiscal year 1997/98. When compared with the previous budgets and allocations suggested by BOD analysis, the results revealed an even more disparate picture.

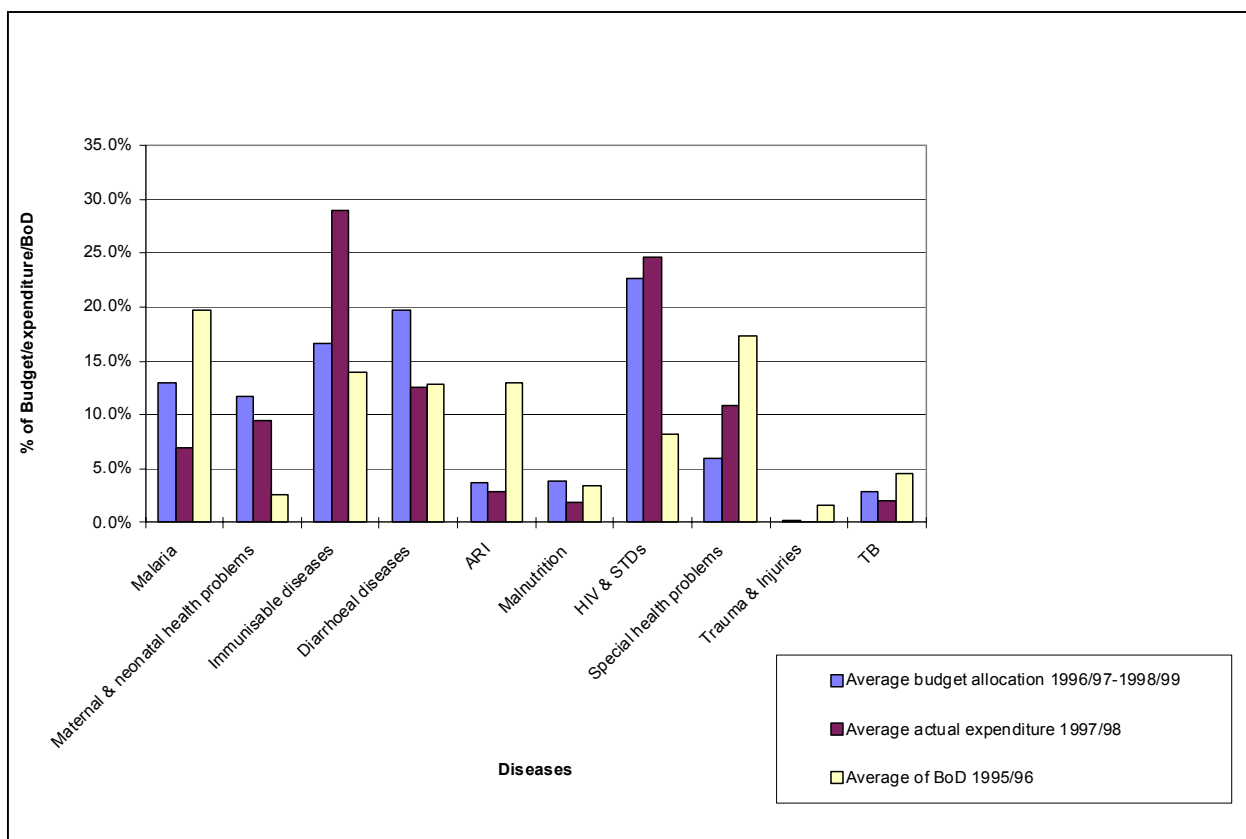


Figure 6. A comparison of BoD 1995/96 vs Budgeted and Actual expenditure

Expenditures for malaria, which is the cause of the largest proportion of the burden of disease, were much lower than the budget allocation for malaria control, and lower than the budget allocation suggested by the BOD/CE. Expenditures on immunization were higher than what had been budgeted by the districts; these were even higher than suggested by the BOD/CE.

For STD/AIDS control, actual expenditures were only slightly higher than district budgets, but still far above what the analysis indicated. Expenditures for the prevention of diarrhoeal diseases (water and sanitation) seemed consistent with the BOD/CE, but district budgets were much higher than what the process indicated would be appropriate.

The interviews

The picture of BOD/CE emerging from the interviews was generally a positive one. The approach taken was considered suitable for more rational planning and budgeting in the future. Reservations were expressed about methodological shortcomings, such as the possibility of unreliable data and the absence of political priorities.

When asked about health plans and budgets before and after the concept of BOD/CE was introduced, respondents were overwhelmingly receptive to the change. The method appeared to be useful since data generated *could be used to substantiate requests for additional funds*. Planning and budgeting were now perceived as more “scientific”, as they addressed disorders according to burden of disease and cost-effectiveness, with a smaller proportion of funds being allocated for administration.

With regard to criteria other than BOD/CE used by the respondents in health planning and resource allocation, “other priorities” set by the center, and “community participation and involvement” were mentioned. Availability of funds, personnel, equipment, and additional resources were also cited. Other diseases causing health problems, but not necessarily deaths (e.g., river blindness, skin diseases, and oral health problems) were priorities that were not captured by the BOD concept.

When asked to comment on constraints or obstacles in using the BOD/CE method for planning and resource allocation, the respondents particularly mentioned “inadequate information” and “lack of capacity to analyze data”. The fact that funds are often earmarked for certain purposes was viewed as a problem, as was the general shortage of funds for providing services. It was also felt that political priorities often conflicted with BOD priorities. In addition, several respondents mentioned that the BOD/CE method was not well understood by staff.

Among suggested ways to improve the BOD/CE method were availability and quality of data and increased capacity for analysis. A larger budget and, above all, *political commitment* to the budget were other issues raised.

When respondents were finally asked how optimal health planning and resource allocation could be conducted at the district level, the most crucial factor stated was guaranteed availability of resources. More reliable, timely, and flexible funding was desired. An increase in bottom-up planning from the community level was seen as

paramount, as was increased collaboration with NGOs and donors. Timely planning, enhanced planning capacity, and more involvement of politicians and planners in the process were also issues raised.

BOD/CE failed as a budget allocation instrument at the implementation level because of internal, technical weaknesses of the method itself, and because of its lack of sensitivity to non-technical issues on local level, e.g., political priorities and demands by the local population. It was still well-liked by the local officials using it, as they found it facilitated the presentation of health data to decision-makers in the districts.

General discussion

The aim of this thesis was a) to investigate strengthening needs-based health care services by means of implementing of a national health policy in the decentralized health care system of Uganda, b) to identify possible impediments in this process, and c) to examine the value of theories such as diffusion and translation of ideas in the interpretation of policy implementation and health sector reform.

Our findings indicated that when provided with the power to approve their own budgets, local authorities did not make health care a financial priority. Nevertheless, this attitude seemed rational from the point of view of the district politicians and civil servants. From a translation perspective, however, the perception of rationality in the local context did not appear as favourable to health as the MOH desired. Powerful individuals, such as local politicians, created their own priorities, which were seen as rational from their viewpoint.

The SWAP process has changed the relationship between the various actors in the health sector. The working relationship between donors and the MOH has been facilitated and interaction strengthened. Health policy has thus become a more central instrument for the management of health services, while steering has become more indirect. However, top-down communication between the MOH and the districts still predominates, and significant elements of direct steering remain. As a consequence, the rationality for health planning and prioritization tends to develop in different directions. The centre tends to adopt the same rationalities as the international health agencies and the donor community, while the periphery tends to be governed more by perceived local needs and power relations.

The restructuring of the MOH has also changed the interaction between it and the districts. For one thing, the districts have become increasingly dependent on the MOH, and the interaction with regard to central planning has intensified. However, when it comes to technical programmes, the interaction has decreased. Despite the fact that policy implementation and management calls for a more indirect steering from the centre, the technical programmes continue the old pattern of direct steering.

The adoption of new policies, paradigms, and strategies has strengthened the links between the MOH and global institutions, leading to a further alienation of the MOH from agencies responsible for implementing the policies. Since the structure of the MOH resembles global institutions more than it does Ugandan service providing agencies, the policies and paradigms of the MOH will be likely to undergo a translation process in adjusting to local contexts. This can only be done to a limited extent: policy elements of global origin are accepted as fairly rigid by planners at the central level, and they seem to expect them to diffuse from the global institutions via the MOH throughout Uganda without transformation.

Rendering these policies concrete so that they maybe used for guidance at the implementation level remains problematic.

The situation described above is typified by the fact that the district health budgets, which highlighted the intentions of the districts, failed to follow the BOD pattern, as expected by the MOH. Actual expenditures, reflecting what the districts were in fact doing, deviated even further from the BOD pattern. BOD/CE can be seen as an example of enforced adoption of a complex instrument that has been subject to a translation process before its application at the peripheral level. The conclusion from Uganda is that such forced policy elements are difficult to implement according to their original intentions and, as a result, have little impact on local practice.

In this study, the application of translation theory seemed to work better than the commonly applied diffusion theory for health policy, primarily because it was implemented in a context different from the one in which it originated. Among other reasons for the success of translation theory were the important changes in power relationships that came with decentralization. There seems to be a general assumption that new health policies can be implemented by means of fairly uncomplicated diffusion processes. However, our analysis of the failure of the BOD/CE initiative shows that implementation of a health policy in the decentralized government system in Uganda is complex. It must be viewed in hindsight as a translation process that went in an undesired direction because its prerequisites were lacking.

Strengths and limitations

The design of any study has its limitations. Similarly, the interpretation of research findings may be conditioned by methodological issues. A study may also have strengths that may balance such limitations. These strengths and weaknesses are considered below.

A strength of the present study is that it was undertaken within the framework of a social experiment—perhaps the only way to study a phenomenon of this kind. Uganda was particularly suitable as a natural laboratory due to the availability of critical data. With regard to methodology, the participatory approach generated a richness of data and a framework for data analysis, in addition to ensuring access to that data in the form of interviews with key persons. The approach also provided an understanding of who the main figures really were, something that can be difficult to determine from the outside. In all likelihood, it improved the validity of the information gathered, since biases such as inflated “success stories” were easier to detect and therefore avoid.

Regarding limitations, my direct participation might be faulted as creating a lack of objectivity. This potential shortcoming was addressed by availing myself of

scientific methodology to gather a large quantity of detailed information, and by the analytical process that followed. There is always the risk that an applied theory might provide an inadequate framework for analysis by virtue of its incompleteness, vagueness, etc. However, translation theory is capable of sustaining different types of rationality than those held by the health policy makers in this instance. Ethnic belonging, for example, which often is raised as a prerequisite to understanding in African countries, is not a barrier to the employment of translation theory.

Earlier research in this area

The difficulty of policy implementation in areas other than public health is well known and has been an object of study over a long period of time. However, in the health sector, very few studies directly problematize this issue. One of these is the work of Gilson & Mills (1995) which *inter alia* stresses the need for more information on the implementation and operationalization of reforms, particularly with regard to the issue of how influence governs context, actors, and processes. Møgedal, Hodne-Steen, and Mpelumbe (1995) conclude that more attention needs to be directed to analyzing the preconditions for (and implications of) reform efforts and ensuring consistency.

Rather than addressing the entire health sector, the few studies that do exist in this field focus on a subsector or a limited topic. One such study (Maynard & McDaid 2003) calls for more evaluations of medical technology. Such restricted studies have become more prevalent with the increasing interest in evidence-based medicine. Few of them, however, have been carried out in low-income countries. Those studies supported by a theory capable of guiding the interpretation of data collected or generalizing the findings are even fewer. A recent exception to limitations of this kind is found in a study of the implementation of national drug policies in Laos and Vietnam (Jönsson 2002), in which the paradigm of policy translation is applied for the first time in this area. Jönsson deals with the problems arising when external policy elements penetrate the national boundaries of low-income countries, raising and analyzing the issue of coercive diffusion of a policy.

My thesis attempts to address the whole health sector from a policy implementation perspective by studying specific examples (like BOD/CE), while simultaneously applying a theoretical approach in order to make the examples available to comparative research and applications in different environments.

Practical implications of the results

A significant factor inhibiting successful policy implementation has been the gap that exists in a social system between the centre and the periphery. It is evidenced by a difference in values, failure to share common framework of knowledge, and a lack of needed support—all resulting in local obligations and accountability becoming the main steering factors of the translation process. Implementation of a policy depends heavily on the ability to market it to the people who are responsible for the allocation of funds. In the case of Uganda, these are the local politicians. Communication between the MOH and the districts has been a complex issue, characterized by limited interaction and insufficient coordination on the part of the MOH, with the MOH focusing on district health professionals, rather than on other key figures such as politicians, general administrators, and local lay leaders, all of whom would have had the power to raise funds as well as mobilize the community. This is especially apparent with the old technical, vertical programmes, against which the AIDS Control Programme is a brilliant exception.

Many technical officers, including physicians, are simply not trained to communicate with other cadres outside the ministry. In order to successfully implement a programme, dispatching circulars to the districts probably does not suffice; more direct interaction appears to be needed. Individual networking is likely to play a primary role in policy translation. However, in order to communicate well, familiarity with the local context is a *sine qua non*. This includes the possession of general and specific knowledge of the situation prevailing in each district. It also includes first-hand knowledge of how the District Director for Health Services (DDHS) and the DDHS team works, as well as knowledge of local government and the roles played by the various functionaries in this structure.

Managerial steering in a decentralized context needs to be indirect in order to avoid conflicts with lower-level decision makers. This is probably even truer when a “holistic”, overall decentralization has been carried out, such as the one in Uganda. Here, the tension seems to revolve around the relationship between central health professionals on one side and local politicians and administrators on the other, two groups who differ considerably in terms of cultural background, values, experience, and style of work. The difference is even greater when juxtaposing representatives from the global expert community with representatives on the local level.

In order to bridge the gaps between the various levels of involvement, national representatives must have strong backing from local representatives at meetings and conferences, and must ensure that the arguments they present are ones that are well-embedded in the local community. Elected representatives of the local

community and lay leaders must be invested in the plan. It would also be highly desirable to bring visiting global representatives to peripheral areas to engage in direct interaction with health facility staff and local community leaders.

Professionals may have a good technical knowledge of local level health services, but they are not the leaders of the community. Only through the local leaders can the community be reached and understood. The power relations in a district have to be comprehended and acknowledged in order to achieve successful implementation.

The key to the implementation of a policy or a paradigm—and to decreasing the gap between policy makers and policy implementers—is simplicity. Ideas and views are more readily accepted by local decision makers if local conditions can be discussed and incorporated during the negotiation process. Uganda's current health policy and strategic plan, whose logical framework has been praised by donors, may work well on the central level. Its prescriptions, however, have been difficult to embed in the local soil of the districts. Much effort has been expended on understanding these complex matrices, which are alien to people's ways of thinking on the local level. It has been difficult to reconcile them with other plans in the districts in order to make practical sense.

If the policy were broken down into its constituent ideas as a substrate for implementation at the district level, the process would become more understandable and fertile. It would enable the policy elements to be integrated into the local activities in the district, and would allow local variations. The entire process should be seen as a long-term undertaking in which policy elements can interact with local issues over time.

The importance of the issues outlined above can be better appreciated from the perspective of the theory of policy translation.

Theoretical implications

In order to improve research on health policy implementation and health sector reform, theories are needed that can help understand the problems involved. Such theories might also facilitate comparisons between different policies and situations. For research in low-income countries, it is of special importance to comprehend the relevance of varying contexts. Most paradigms and policies, whether sector-wide or narrow, are developed in affluent countries and later more or less imposed on low-income countries with a certain degree of coercion. This process is usually performed uncritically. The need for a policy flexible enough to adjust to new contexts is not sufficiently recognized—a fact which contributes to implementation failure.

A first step would be to give the current, largely untheoretical research a theoretical basis. This can be done by learning from disciplines such as political science, sociology, and social anthropology. Although it is desirable to employ methods that are relatively simple, theories cannot be too simplistic if they are to account for the nuances of the objects studied. In seeking to explain policy implementation, we have applied translation theory. In many cases, however, the simpler and more commonly used diffusion theory may suffice. Our intention was to study the dissemination of policy elements through different strata of political contexts and societal power relations. It became clear at an early stage that the local environment had a heavy impact on policy implementation. As this could not be explained by diffusion theory, it was necessary to search for something more complex in order to address a multifaceted situation.

Where one theory cannot cover all aspects, additional theories must be engaged to account for specific aspects and situations. The typologies of direct and indirect steering were introduced to demonstrate how steering had to change with decentralization in order to remain effective. Concepts like top-down and bottom-up were used to describe different foci of implementation.

It seems likely that studies like the present one, which take place in the intersection between medicine, social science, governmental studies, and economics, can benefit from theoretical and methodological cross-fertilization.

Conclusions

- When provided with the power to approve their own budgets, local authorities failed to make health care a financial priority. From the point of view of district politicians and civil servants, however, these decisions were rational.
- In the health sector of Uganda, the SWAP process has changed the relationship between the various actors: rationalities concerning priorities in health care tend to develop in different directions with regard to the centre and the periphery. The centre tended to adopt the same rationalities as international health agencies and the donor community, whereas the rationalities of those on the periphery tended to be dictated more by local needs and power relations.
- The interaction between the MOH and the districts changed after the MOH was reorganized. Districts were increasingly obliged to rely on the MOH. New interactions between the planning function and the districts became more intense, while the “old” interaction between the districts and the technical programmes became more problematic.
- The adoption of new policies, paradigms, and strategies has strengthened the links between the MOH and global institutions at the expense of further disengaging the MOH from the implementing level.
- District health budgets, while exemplifying a district’s priorities, did not follow the BOD pattern, as the MOH had desired. Actual expenditures, which indicated concretely what the districts were doing, deviated even further. The BOD/CE approach was still favoured by the local officials using it, and was reportedly a useful means of presenting health data to decision makers in the districts.

Sammanfattning på svenska

Decentralisering och genomförande av en nationell hälsopolicy i Uganda – en komplex process

Bakgrund

Ugandas regering har strävat efter att skapa en behovsbaserad och kostnadseffektiv hälso- och sjukvård på två olika sätt: hälsosektorn har decentraliserats för att öka ansvarstagande och medverkan på lägre nivåer. Kompetens har byggts upp för att kunna utveckla en nationell policy, och därigenom kunna bedöma sjukvårdsbehov och för att göra kostnadseffektiva prioriteringar.

Syfte

Syftet med denna avhandling är att undersöka processen med att genomföra en nationell hälsopolicy i Ugandas decentraliserade hälso- och sjukvårdssystem .

Population och metoder

Hälsosektorn i Uganda har undersökts från nationell nivå ner till distriktsnivå. Fokus har riktats mot decentraliseringsprocessen, som också förutsätter en effektivare mekanism för att genomföra policymål genom hela det decentraliserade systemet sedan de traditionella hierarkiska styrningsmetoderna blivit föråldrade. För att studera genomförandeprocessen har *nyinstitutionalismen inom organisationsteorin* används som teoretisk ram. De olika uppsatserna i avhandlingen behandlar perspektiv som är viktiga för att förstå förutsättningarna för policygenomförande i ett decentraliserat system. Den sista uppsatsen bedömer och tolkar också ett fullskaligt genomförandeförsök mot bakgrund av de föregående studierna. Diffusions- och översättningsbegreppen från *nyinstitutionalismen* används som verktyg i analysen. Som övergripande metod har deltagande observation använts. Intervjuer, enkäter, fokusgruppdiskussioner och dokumentstudier har nyttjats för att samla in data.

Resultat

Den finansiella decentraliseringen studerades, och det antogs att distrikten skulle prioritera hälso- och sjukvård ekonomiskt, för att därigenom följa den nationella hälsopolicyn. Så befanns emellertid inte vara fallet.

När ”Sector-Wide Approach” (SWAP) studerades, framgick det att medan förmågan att utveckla policier blev starkare i hälsoministeriet hade den centrala förvaltningen samtidigt svårigheter att upprätthålla en effektiv samverkan med distriktsnivån. Detta ledde till att en klyfta skapades mellan centrum och periferi.

Omstruktureringen av hälsoministeriet studerades, och det noterades att medan hälsoministeriet nu mer fokuserar på policyformulering än på detaljstyrning av hälso- och sjukvårdssystem, finns det ändå en växande klyfta mellan centrum och periferi.

Fastställandet av nya policier, paradigmer och strategier, som t. ex. SWAP, omstruktureringen av hälsoministeriet och framtagandet av en ny hälsopolicy, har förstärkt relationen mellan hälsoministeriet och globala institutioner genom att värderingar och paradigmer är likartade. Emellertid har denna process sannolikt också bidragit till att hälsoministeriets lokala förankring har minskat.

Tillämpningen av normativa och rationalistiska verktyg som Burden of Disease (BOD), kombinerat med kostnadseffektivitet för att genomföra den nationella hälsopolicyn på distriktsnivå studerades. Detta tillämpningsförsök bedömdes som ett misslyckande.

Diskussion

Den ökade decentraliseringsgraden av hälsosektorn i Uganda har under studieperioden inte åtföljts av ett välbehövligt och framgångsrikt genomförande av en övergripande nationell hälsopolicy som ledstjärna för ett decentraliserat hälsosystem. Det förefaller som om beslutsfattare antagit att nya hälsopolicies skulle kunna genomföras genom en tämligen okomplicerad diffusionsprocess. Emellertid visar vår analys av det misslyckade försöket att använda BOD/kostnadseffektivitet som budgetallokeringsredskap, att genomförande av en policy i det decentraliserade systemet i Uganda är av komplex natur och att detta snarare bör förstås som en översättningsprocess i en oönskad riktning, dvs. att förutsättningar saknades för en översättningsprocess i önskvärd riktning.

Den främsta svårigheten förefaller vara klyftan mellan centrum och periferi, vilken innebär att man inte delar samma värderingar och referensramar, och att man lider brist på nödvändigt understöd från ömse håll. Detta innebär i sin tur att lokala förpliktelser och ansvar sannolikt kommer att bli de faktorer som främst styr policyöversättningen.

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